



Patient Information Form- please print

Patient Name _____ Date of Birth _____ age _____

Address _____ Home phone _____

City _____ State _____ Zip _____ Cell Phone _____

Email address _____ Marital status M S W D Gender M F

Would you like to receive information regarding our product specials, educational seminars and events?

Yes No

Employer _____ Phone _____

May we contact you at work? Yes No Social Security # _____

If under 18:

Mother/Legal guardian Name _____ Phone _____

Address _____

Father Name _____ Phone _____

Address _____

How did you hear about our office? _____

Next of Kin/ Emergency Contact _____ Phone _____

Please indicate if there is anything we need to know to provide you more personal care _____

I realize that skin care is cosmetic and not covered by insurance. I am aware that I am responsible for all charges.

(patient/parent/guardian signature) (date)

(witness signature) (date)

I Have Received a Copy of the the Notice of Privacy Practices at Grand Pearl

grand PEARL

SKIN BEAUTY BODY

Skin Evaluation

Have you had previous skin treatments? Yes No

What are you interested in?
(please check all that apply):

- Skin Care Treatments _____
- Skin Care Products _____
- Make-up _____
- Laser Skin Renewal _____
- Botox _____
- Filler _____
- Surgery _____
- Longer Eyelashes _____
- Hair Removal _____
- Micro Needling _____
- Platelet Rich Plasma(PRP) _____
- Diva _____
- Tattoo Removal _____

What are your main concerns?
(please check all that apply):

- Sun Damage/Age Spots _____
- Aged Skin _____
- Texture _____
- Wrinkles _____
- Uneven Skin Tone _____
- Acne _____
- Large Pores/Blackheads _____
- Oily Skin _____
- Dry Skin _____
- Unwanted Hair _____

- Ethnicity:**
- Asian _____
 - Black _____
 - Caucasian _____
 - Hispanic _____
 - Mediterranean _____
 - Middle Eastern _____

Health History- check if you:

- | | | |
|-------------------------------|------------------------------------|----------------------------------|
| Have Used Accutane _____ | Bleeding Disorder _____ | Thyroid Hormone Deficiency _____ |
| Had Gold Injections _____ | Platelet Disorder _____ | Diabetes _____ |
| Are Pregnant _____ | Hepatitis _____ | Hypertension _____ |
| Are Lactating _____ | HIV _____ | Heart Disease _____ |
| Are Prone to Cold Sores _____ | Seizures _____ | Currently have any active _____ |
| Chemotherapy _____ | Hirsutism _____ | Infections _____ |
| Kidney Disease _____ | Polycystic Ovarian Disease _____ | Have an auto immune _____ |
| Cancer _____ | Lupus, Vitiligo, Scleroderma _____ | Disorder _____ |
| Keloid scars _____ | Steroid or Hormone Therapy _____ | |

Allergies/Skin Sensivities: _____

Current Medications(including blood thinners, supplements, and any topical medications): _____

Pigmentation/Hormones:

- Do you have regular periods? Yes No
- Are you going through menopause? Yes No
- Did you get hyperpigmentation (pregnancy mask) during pregnancy? Yes No

- Do you have:**
- Broken Capillaries _____
 - Rosacea _____
 - Redness _____

Sun Exposure:

- Do you wear sunblock? Yes No When was your last sun exposure? _____
- Have you had skin cancer? Yes No Do you use self-tanning lotion? No Yes (when? _____)

When in the sun without protection, do you *(circle all that apply)*:
always burn • sometimes burn • never tan • sometimes tan • eventually tan • always tan

(patient print name)

(patient signature)

(date)